IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6289

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	MR JOHN OLLE, CORONER
Deceased:	BRADLEY DOBNEY
Date of birth:	23 FEBRUARY 1991
Date of death:	15 DECEMBER 2018
Cause of death:	1(a) IMMERSION IN THE SETTING OF A MOTOR VEHICLE INCIDENT
Place of death:	WESTERN RING ROAD/PRINCES FREEWAY INTERCHANGE, LAVERTON NORTH, VICTORIA 3026

INTRODUCTION

1. On 15 December 2018, Bradley Dobney (**Brad**), aged 27 years, died in a motor vehicle accident. Brad was the driver of the vehicle, and his passenger and best friend, Jason Gilham, also died in the accident.

2. Brad was the son of Anne and Noel Dobney, and had two older sisters, Rachel and Sarah. At the time of his death, Brad lived in a share house in Sunshine with a friend, Edward Robson.

3. Anne and Noel described Brad as a "very social person" who had many friends and was easy to get along with. They said, "he loved people and everybody loved him".

4. Brad had a tightknit group of friends, most of whom he had known since childhood, including Jason Gilham, Liam Hill, Mike Batten and Tom Greaves. Jason and Brad met growing up when they played cricket together, and Jason's parents said the two became closer later in life due to their mutual love of cars. Brad, Jason, Liam, Tom and Mike all shared this passion, and would often work on cars together.

5. Brad worked as a motor mechanic for Mercedes Benz where he commenced as an apprentice at age 17. He worked elsewhere for a short time before returning to the company where he was promoted to Workshop Supervisor approximately six weeks prior to his death. As part of his promotion, Brad was given a new white Mercedes Benz GLA180 to lease, and although he had only driven the car for about six weeks, he was intimately familiar with the vehicle due to his work. Both his parents and his friends noted that he was a cautious driver, particularly now that he drove a company car.

Medical history

6. Bradley's medical records revealed he had a history of appendicectomy, kyphosis, obesity and abdominal pain. He also experienced occasional 'fainting spells' and was investigated in 2011 by a cardiologist with his sister who also experienced similar episodes. The cardiologist's review did not reveal any significant cardiac abnormality, however, it was noted that Bradley was prone to neutrally-mediated syncopal episodes (episodes of low heartbeat, low blood pressure and brief loss of consciousness), usually triggered by prolonged standing or stress.

THE CORONIAL INVESTIGATION

7. Bradley's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Bradley's death. The Coroner's Investigator, Sergeant Evan Brown, conducted inquiries on my behalf, including taking statements from witnesses from family, the forensic pathologist, treating clinicians and investigating officers – and submitted a thorough coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Bradley Dobney, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. On 15 December 2018, at approximately 7:00pm, Brad drove himself and Jason to Lazy Moe's restaurant in Caroline Springs, where they met up with Mike and Tom. The group had dinner together and Brad drank one Corona beer and one James Boags light beer.

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. The group finished their meal at approximately 8:20pm. According to Mike, the four young men went outside to see Brad's new car and talked for another 10-15 minutes before leaving. As far as Mike and Tom were aware, Brad was driving himself and Jason to Jason's house in Hoppers Crossing to work on a car and have a few drinks.

14. Both Tom and Mike said that after leaving the restaurant they pulled up next to Brad and Jason on Chisholm Drive at the intersection of Ballarat Road. Tom and Mike turned left, while Brad and Jason turned right onto Ballarat Road.

15. After 8:30pm, a witness reported seeing a car which matched the description of Brad's Mercedes Benz four-wheel drive travelling along the Western Ring Road at Derrimut past McDonald's and 7 Eleven. The witness stated she noticed there were two young men in the car.

16. At approximately 8:45pm, a male driver on the Western Ring Road said he noticed a "newish white four-wheel drive" in the left-hand lane as he approached the Princes Freeway, Geelong exit. The witness stated he was travelling at 90km per hour and noted that the white four-wheel drive was slightly ahead and travelling approximately 80km per hour. According to the witness, as both cars approached a right-hand bend at the entrance to the Princess Freeway, the white four-wheel drive failed to turn and continued straight. He said the vehicle "didn't appear to turn at all, just straight, straight, straight". The car mounted the curb striking a chevron sign, before disappearing down the grassed embankment.

17. A female driver and her daughter also observed the white Mercedes four-wheel drive depart the road and drive onto the embankment followed by "a big cloud" of either dust or water. Concerned by what they observed, they stopped and contacted emergency services.

18. Victoria Police officers, Sergeant Evan Brown (formerly Leading Senior Constable Brown) and Senior Constable Ford, arrived at the scene at approximately 9:00pm, followed shortly by Ambulance Victoria paramedic, Stewart MacGregor. While searching the area, Sergeant Brown walked up the embankment adjacent to the Western Ring Road Geelong off ramp and noticed a road sign had been pushed over and there were fresh tyre marks in the grass. Sergeant Brown, SC Ford and Paramedic MacGregor followed the tyre marks down the embankment to the edge of a dam, where they discovered a vehicle upside down and submerged in the water. Only the car's two rear wheels were visible above the waterline.

19. Sergeant Brown and Paramedic MacGregor entered the water to check for occupants in the vehicle. The water was noted to be "particularly dirty" and was subsequently described by a

Victoria Police Search and Rescue Squad officer as "black water" with no visibility. The dam was reed-filled, which made it difficult to move through. On reaching the upturned vehicle, Sergeant Brown recognised the car to be a Mercedes Benz. Paramedic Macgregor and Sergeant Brown searched underwater and tried to open the car's door handles, however, the doors appeared to be locked. Sergeant Brown discovered the rear hatch open, and reached inside, however, was unable to locate anyone. There were no signs of life detected in the vehicle and they became concerned that a substantial amount of time had passed since the incident was reported. Ultimately, they were unable to gain entry to vehicle or reach its occupants while it was in the water.

20. Additional police officers arrived on scene including the Victoria Police Search and Rescue Squad and a Police Air Wing approached overhead. State Emergency Services attended and provided additional lighting. Following an initial assessment with the assistance of Search and Rescue Squad members, the decision was made to remove the vehicle from the water, rather than dive on it. The car was subsequently towed from the water with the assistance of police divers and a tow truck.

21. Once removed from the water, two deceased males were located inside the vehicle and later identified as Bradley Dobney and Jason Gilham. Neither male was wearing a seatbelt, and they were both located in the back section of the car. Jason's legs were protruding from the damaged glass roof and his left arm was noted to be wrapped around Brad, as if he were giving him a hug.

Victoria Police incident investigation

22. Attending police officers including Sergeant Brown and SC Ford examined and measured the scene. The scene was photographed, and statements obtained from witnesses. The conditions were noted to be dry with good visibility, however, the light was fading.

23. The incident occurred at the Western Ring Road/Princes Freeway interchange in Laverton North. Prior to the interchange, the Western Ring Road is a four-lane roadway bordered by emergency stopping lanes on both sides. At the interchange, the road subsequently divides for Geelong bound traffic to enter the Princess Freeway to the right, and city bound traffic to enter the West Gate Freeway to the left. The entrance to the Princess Freeway to Geelong transitions to a two-lane carriage way bordered by paved shoulders. There is a right-hand curve in the road and the left-hand lane is bordered by a grassed reserve which leads down a sloping embankment to a dam. At this section of road, the speed limit reduces from 100km per hour to 80km per hour. There are also two 70km advisory signs at the bend followed by seven yellow and black

chevron arrow signs signalling a curve in the road. At the fourth chevron sign, a guard rail lines the left-hand side of the road.

24. Witnesses reported that prior to the incident, the white Mercedes Benz four-wheel drive was travelling southbound in the left-hand lane, adjacent to the grassed reserve. Tyre scuff marks were present on the paved shoulder where the vehicle left the road, followed by rolling tyre prints on the grassed reserve which led down to where the vehicle was located. The markings confirmed witness accounts that the vehicle had failed to negotiate the right-hand bend in the road, and instead continued straight, over the paved shoulder of the road and onto the grassed reserve.

25. Sergeant Brown inspected the paved road surface of the Western Ring Road where the vehicle veered off track and noted no signs of skid marks, yaw marks, debris, disturbed gravel or any other evidence which would have indicated an incident occurring prior to the vehicle leaving the road. He stated that there was no evidence of the driver having taken evasive action, and that the vehicle continued in a straight line until it entered the dam. The tyre markings indicated the tyres rolled over the surface without braking, acceleration or a change in steering direction. Gouge marks were noted, revealing that the vehicle had been airborne and landed before entering the dam. Sergeant Brown opined that the vehicle became upturned on impact when the front of the vehicle slowed as it entered the water, while the rear of the vehicle maintained momentum.

26. Following removal from the water, Sergeant Brown inspected the vehicle on land and noted all doors to be locked, the boot/hatch open and both rear windows were wound down. The rear seats were in the upright position, preventing access to the boot area. The doors were able to be unlocked by pulling on the handle from inside the vehicle.

27. The vehicle was retained by Victoria Police and later underwent a mechanical inspection by mechanical investigator, Dale Woodland, of the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**). Following inspection, Mr Woodland concluded that the vehicle was in 'as new' condition prior to the collision, and the examination did not reveal any mechanical fault or condition which would have caused or contributed to the collision.

28. Sergeant Brown subsequently requested Detective Leading Senior Constable Michael Hardiman of the CRMCIU review the incident to attempt to determine the speed of the Mercedes Benz when it left the road and travelled down the embankment. DLSC Hardiman reviewed the traffic report, measurements and photographs taken. He noted that there were

'rolling tyre prints' present (a tyre mark left by a tyre that is simply rotating and is neither sliding nor slipping), and stated it was not possible to tell from a rolling tyre print whether a vehicle was under breaking, accelerating or was simply rolling. He stated however that any braking was not sufficient to cause the tyres to lock, and any acceleration was not significant enough to cause the tyres to spin. He also noted that the direct path of the tyre prints indicated the driver did not input any sideways steering. DLSC Hardiman also attempted to calculate the speed of the vehicle by retrieving the vehicle's Event Data Recorder information, however, the data could not be downloaded by Victoria Police.

29. Ultimately, DLSC Hardiman was unable to give an opinion as to the speed of the Mercedes Benz as it left the road and journeyed down into the dam. Consequently, the speed of the vehicle at the time of the incident could not be determined.

30. Sergeant Brown also made enquiries with the vehicle manufacturer, Mercedes Benz, however, the information provided did not assist, save for the manufacturer suggesting that the impact was insufficient to meet the deployment criteria to instigate a crash signal which would have resulted in safety features such as airbag deployment and automatic door unlocking to allow the doors to be opened from the outside.

Identity of the deceased

31. On 19 December 2018, Bradley Dobney, born 23 February 1991, was identified using circumstantial evidence and dental record comparison.

32. Identity is not in dispute and requires no further investigation.

Medical cause of death

33. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 20 December 2018 and provided a written report of her findings dated 6 July 2019.

34. Dr Archer stated that the post-mortem examination revealed no injuries that would have caused death in isolation, and the most likely mechanism of death was drowning. She further noted that there was bruising to the scalp, indicating Brad hit the back and left side of his head which made it possible that he was unconscious at the time of immersion due to concussive head injury (there was no evidence of life threatening brain trauma).

35. Dr Archer referred to an ECG taken on 27 September 2017 which was examined by two separate cardiologists. She noted that both cardiologists assessed the ECG as having a normal T-wave morphology and a normal QT interval, with the ECG considered to be overall within normal limits. Dr Archer stated that the heart size was within normal limits for Bradley's body mass index, and that a cardiac event while driving seemed less likely. Additionally, the autopsy showed no significant macroscopic or microscopic abnormality of the heart.

36. Prior to his death, Bradley was being investigated for abdominal pain, however, the autopsy did not reveal any cause for the pain. Dr Archer further stated that there was no evidence of any natural disease that could have caused or contributed to death.

37. Toxicological analysis of post-mortem samples identified the presence of paracetamol in urine consistent with therapeutic use. Post-mortem vitreous humour biochemistry showed levels of sodium, potassium, chloride, glucose, creatinine and urea with normal post-mortem limits.

38. Dr Archer provided an opinion that the medical cause of death was '1(a) Immersion in the setting of a motor vehicle incident'.

39. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

Medical investigations

40. Following review of the investigations undertaken by Victoria Police, I ruled out mechanical failure, driving conditions, drugs or alcohol and driver behaviour as a cause of the incident. Further, the lack of evidence suggesting a deviation or correction in the vehicle's path is significant. Brad was a responsible, cautious driver. It is unlikely he would have intentionally taken his eyes off the road, whilst negotiating a sweeping bend. I therefore consider driver distraction an unlikely cause of the incident. Consequently, attention turned to whether Brad may have suffered a medical episode while driving which caused him to veer off the road.

41. Early in the investigation, information was provided to the Court and concerns were raised that Brad may have suffered a 'black out' or fainting episode at the time of the incident. As noted, Brad's family and friends reported he had previously suffered such episodes which were investigated by a cardiologist in 2011. Consequently, I sought the assistance of the Coroner's Prevention Unit (**CPU**)[2] to review Brad's medical record and consider whether any medical

[2] The CPU assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner and is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

condition, including previously diagnosed syncope could have caused or contributed to the incident.

Available information

42. Brad's medical records revealed the following:

(a) 5 visits to Westgate Health, largely for minor medical conditions. At one visit (27 September 2017) he was in the toilet at the doctors and had blacked out after standing up. He described feeling dizzy beforehand and lost consciousness for 30 secs or so. His fall against the wall left a hole in the plaster. This was in the setting of having a vomiting illness. Subsequent observations and an ECG were normal.

(b) Review by Dr Susan Corcoran (Cardiologist) in 2011. This occurred because of a family history in two older sisters, of "recurrent neutrally mediated syncope and upper normal QT[3] intervals".

43. Information contained in the Coronial Brief from witness statements revealed:

(a) A report by Bradley's parents of him fainting when visiting a friend with a broken arm at the age of 15.

(b) Reports by friend, Liam Hill, of:

(i) A blackout in October 2013 that occurred without warning whilst at a BBQ. Alcohol had been consumed at this time.

(ii) A blackout in June 2017 that occurred when Bradley stood up from a table and fell over. Her looked momentarily vague. No alcohol was involved on this occasion.

(iii) A reported episode whist driving in 2014, although it is not clear if this was a blackout.

[3] QT interval is the time from the start of the Q wave to the end of the T wave of the ECG. It represents the time taken for ventricular depolarisation and repolarisation. The QT interval *shortens* at faster heart rates and *lengthens* at slower heart rates.
Congenital long QT syndromes are associated with an increased risk of ventricular arrhythmias, especially 'Torsades de Pointes' and sudden cardiac death.
Congenital short QT syndrome has been found to be associated with an increased risk of paroxysmal atrial and ventricular fibrillation and sudden cardiac death. Some medications are known to prolong the QT interval and result in cardiac arrhythmias.
QT interval pathology is not identifiable at post-mortem examination.

44. The review by Dr Corcoran was particularly relevant. She noted the following:

(a) A history of classic neurally mediated syncope associated with prolonged standing or seeing sick or injured friends/relatives. These episodes were not suggestive of a disturbance of heart rhythm as mechanism.

(b) A normal ECG with a normal QT interval.

(c) A normal QT interval at rest but does not shorten the QT interval during normal sinus arrhythmia[4].

45. The medical record also revealed Dr Corcoran subsequently arranged for Bradley to undergo a stress test to evaluate his QT dynamics further with a review appointment in 3 months. She also advised him to avoid QT prolonging drugs and electrolyte disturbances. However, Dr Corcoran's notes recorded that Bradley cancelled the stress test and 2 review appointments in March 2011 and she had no further contact with him.

46. As noted earlier, Bradley's ECG from 27 September 2017 was reviewed and considered to be normal by two other cardiologists. Both Professor Jitendra Vohra and Dr Mark Perrin would be considered experts in the field of cardiac rhythm disorders. Both cardiologists assessed the ECG as having a normal T-wave morphology and a normal QT interval, with the ECG considered to be overall with normal limits.

47. Whilst Bradley did not undergo further testing as recommended by Dr Corcoran, it is unlikely that he had a congenital QT syndrome that put him at risk of sudden cardiac death. As Dr Corcoran described, his previous collapses appeared to be typical for neurally mediated syncope (**NMS**) and his ECG was essentially normal.

48. NMS is the most common form of fainting. It is benign and rarely requires medical treatment and is more common in children and young adults, although it can occur at any age. It happens when the part of the nervous system that regulates blood pressure and heart rate malfunctions in response to a trigger, such as emotional stress or pain. NMS typically happens while standing and is often preceded by a sensation of warmth, nausea, light-headedness, tunnel vision or visual "grey-out." Placing the person in a reclining position restores blood flow and consciousness.

[4] Sinus arrhythmia (SA) is non-pathologic baseline variation of the heart rate with respiration. The QT interval normally varies with heart rate, but this variation occurs to a lesser extent in those with short QT syndrome.

49. Syncope can also be related to certain physical events, such as violent coughing, and this has been used as an explanation for similar events in the past. However, there is no indication that Bradley was unwell at the time of the incident.

Conclusion

50. Whilst it is unlikely that Bradley had a sudden cardiac event due to a congenital cardiac electrophysiological problem, it is possible that he suffered syncope for some other reason. However, when considering the findings of Dr Corcoran and the general circumstances in which Bradley had previously fainted (whilst unwell, associated with alcohol or witnessing unwell/injured persons), it would be speculative to conceive of a scenario that could have provoked an NMS type response in Bradley whilst driving.

51. Consequently, I am unable to conclude whether or not Brad suffered a medical event which caused or contributed to the collision.

Installation of barriers at the incident location

52. A short distance from where Brad's car left the roadway, there is a roadside safety barrier which borders the curve in the road at the Western Ring Road Geelong-bound exit ramp. Notably, the guardrail does not cover the area where Brad's car left the road and the car was able to travel unimpeded down the embankment. Consequently, my Coronial Investigator proposed I make a recommendation that the existing safety barrier be extended to prevent vehicles from leaving the road at that section of road. It was also suggested that an additional barrier be installed along the road on the northern side of the grassy reserve to protect Melbourne bound traffic. Brad's family strongly supported this recommendation and I considered the recommendation sound and reasonable.

53. While the suggested recommendation focussed on the incident location, I also considered there may have been broader prevention opportunities. Accordingly, I consulted with the Department of Transport and sought their input in respect to a proposed recommendation that '...safety barriers be installed in the vicinity of any waterways to prevent similar events in future.'

54. In response to the Court's correspondence, Executive Director Metro North West, Alan Fedda, of the Department of Transport advised that, following the incident, they conducted a review of the existing road infrastructure (including the existing roadside safety barrier) and concluded that the existing infrastructure did not breach the applicable safety and design standards. However, Mr Fedda further noted that the current approach adopted by Victoria, 'the safe system approach', provides for broader indicators in the assessment of road hazards.

Consequently, regarding the incident site, Mr Fedda stated, "this approach would require further consideration to the road geometry, steep roadside embankment, and nearby body of water that is likely to warrant further extension to the existing nearby barrier". Mr Fedda further noted that the current Austroads Guide to Road Design Part 6 is currently being updated to further align with the safe system approach for the treatment of hazards to further minimise the risk of fatalities and serious injuries.

55. Significantly, Mr Fedda stated that "this improvement to extend the nearby barrier will be considered for funding in a future program once the West Gate Tunnel Project is completed".

56. In response to my specific recommendation which extended more broadly than the incident site, the Department of Transport considered that such a recommendation would not be appropriate as:

    (a) "the definition of waterways captures a range of bodies of water, not all of which are relevant to the road network, and

    (b) A broad-brush recommendation such as this does not recognise the risk-based approach that DOT takes in relation to road safety".

57. The Department of Transport accurately pointed out that the proposed recommendation and use of the language 'waterways' would include many water environments including wetlands, of which there are 35,000 in the State, and this would pose funding and environmental challenges. An excerpt from the Austroads guide to road design relating to hazard identification was included with Mr Fedda's correspondence, and listed hazard examples which included 'bodies of water' as the relevant hazard classification.

58. I consider the Department's response to my proposed recommendation eminently reasonable, and I have therefore framed my recommendation in line with the preferred safe system approach which appropriately applies a risk-based approach to identifying and assessing road hazards, including 'bodies of water'.

Implementation of automatic unlocking sensors in vehicles

59. Sergeant Brown also proposed a recommendation be made that 'car manufacturers worldwide consider implementing auto unlocking sensors for inverted and submerged vehicles.' In considering the recommendation, I consulted with the Federal Chamber of Automotive Industries (**FCAI**) and sought their feedback regarding making a coronial comment that

manufacturers selling new vehicles in Australia consider implementing auto unlocking sensors when a car is inverted and/or submerged in water.

60. As part of their response to the proposal, the FCAI advised that Australia contributes to the development of global vehicle regulations through their participation in the World Forum for Harmonisation of Vehicle Regulations and has a policy of harmonisation whereby the Australian Design Rules **(ADRs)** are aligned with the relevant United Nations Economic Commission for Europe regulations. They noted that the alignment of the majority of ADRs ensures vehicles offered for sale in Australia are equipped with the latest available safety technologies. The FCAI further commented that Australia "represents a very small percentage of the overall vehicle market, with overall sales representing around 1% of global production". Consequently, they stated that Australia is normally a "technology taker", not a "technology maker".

61. The FCAI explained that the international approach to consideration of mandating a new technology would require consideration of incidence rate of this type of event and a cost benefit analysis worldwide. They opined that the cost benefit analysis would make the adoption of such an ADR or international standard unlikely given the rarity of this type of incident. Consequently, I agree that such a recommendation would have limited utility as it would be unlikely to be implemented as a standard safety feature in Australian vehicles.

FINDINGS AND CONCLUSION

62. Having investigated the death of Bradley Dobney and having considered all of the available evidence, I am satisfied that no further investigation is required.

63. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Bradley Dobney, born 23 February 1991;

    (b) the death occurred on 15 December 2018 at the Western Ring Road, Laverton North, Victoria, from immersion in the setting of a motor vehicle incident; and

    (c) the death occurred in the circumstances described above.

64. Regrettably, despite exhaustive investigations, the cause of the vehicle leaving the roadway in this case cannot be identified. The evidence suggests that Brad was a responsible driver who seemed well, and both men were in good spirits immediately prior to the incident. No concerning driving behaviour was witnessed before the car veered off the road, and there was

no evidence to suggest that driver distraction was a contributing factor. It was evident that the two friends tried their best to escape the vehicle, and although they were unsuccessful, comforted each other.

65. I commend and acknowledge the professionalism of Victoria Police and Ambulance Victoria first responders, and members of the Victoria Police Search and Rescue Squad. Their determined efforts to extract the occupants in extremely challenging circumstances, though unsuccessful, were remarkable.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

66. I note that the Department of Transport have stated that the extension of the barrier at the Western Ring Road Geelong-bound exit ramp (where the Western Ring Road connects to the Princes Freeway) will be considered for funding in a future program once the West Gate Tunnel Project is completed. Consequently, I do not consider it necessary to make a formal recommendation regarding the extension of the barrier, however, I encourage the Department to consider the project as a high priority.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(a) Using the risk-based 'safe system approach', the Department of Transport should conduct a review of Victorian roads in the vicinity of 'bodies of water', to identify and consider whether safety barriers should be installed or extended to protect against potential water hazards.

I convey my sincere condolences to Brad's family and friends for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Mr Noel and Mrs Ann Dobney, Senior Next of Kin

Karen Macdonald, Department of Transport

Tony Weber, Federal Chamber of Automotive Industries

Sergeant Evan Brown, Coroner's Investigator

Signature:

JOHN OLLE
CORONER

Date: 14 January 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.